APPLICATION FOR IOWA TEMPORARY PHYSICIAN LICENSE

IOWA BOARD OF MEDICINE
400 S.W. 8th Street, Suite C, Des Moines, IA 50309-4686
515-281-6641

This application is used by individuals who are applying for a temporary license and do not have a social security number.

Instructions for Completing the Application

1. It is important to follow the instructions in each section of the application.

2. Do not leave sections of the application blank. If a section or an item within the section does not pertain to you, indicate that it is not applicable by placing an "NA" in the section or item.

2. Use the accompanying Checklist to complete the application. Not all forms in this packet will apply to all applicants.

3. For additional space to complete any section, attach a separate sheet of paper labeled with the appropriate section number. Sign and date each attached sheet.

Using this Application Form on the Computer

1. This application packet may be saved to your computer, because the application is a PDF file. To save this file, click on the icon that looks like a diskette. This toolbar should be located above the document.

2. When completing the application on the computer, you will not be able to save the information entered to print at a later time. Print any completed pages immediately.

3. Use the Tab Key to move from field to field.

4. Some of the fields allow multiple lines of text. Be sure that all text entered can be viewed when moving to the next field. Information that is not visible on the form will not be printed.

5. Some fields (such as the last name field) have word wrap due to the size of the field. Continue to type the information even though it may break to the next line. It may not look as nice, but it is necessary to get all the information visible on the application.

Application for a Temporary Iowa Physician License

IOWA BOARD OF MEDICINE
400 S.W. 8th Street, Suite C, Des Moines, IA 50309-4686, (515)-281-6641

Section 1—Type of Activity

Indicate the type of activity you will be participating in under the temporary license. If you have questions, call (515) 281-6641.

Temporary License—$145 Application Fee

This license is for physicians who are participating in one of the following board approved activities. Temporary licensure is not meant to be used as a way for a physician to practice before permanent licensure is granted. It is not intended for locum tenens physicians. Indicate which board approved activity you will be participating in.

_____ Covering for an Iowa licensed physician who unexpectedly is not available to provide medical care to his/her patients.

_____ Demonstrating or proctoring that involves providing hands-on patient care to patients in Iowa.

_____ Conducting a procedure on a patient in Iowa when the consultant's expertise in the procedure is greater than that of the Iowa-licensed physician who requested the procedure.

_____ Providing medical care to patients in Iowa if the physician is enrolled in an out-of-state resident training program and does not hold a resident or permanent license in the home state of the resident training program.

_____ Serving as a camp physician.

_____ Participating as a learner in a program of further medical education that allows hands-on patient care when the physician does not currently hold a license in good standing in any United States jurisdiction.

_____ Another activity approved by the Board.

Applicant Name:

Section 2— Identifying Information

Complete every item. Enter your full legal name. Do not enter an initial for your middle name, unless an initial is your legal middle name. Licenses are issued in the physician's legal name. List other names you have used, such as a nickname or name that is used on the diploma, if different from your legal or maiden name. Describe any identifying marks, such as scars, birthmarks, or tattoos. An e-mail will be sent to the applicant's e-mail address and the other e-mail address listed after a review of the application is completed. The other e-mail address can be for the person assisting you with the application process.

Full Legal Name:

Last First Middle Suffix

Other Name(s) Used: Check if Not Applicable

Maiden Name:

Current Home Address:
Street, City, State, Zip
(County– for Iowa addresses only)

Home Phone:

Current Work Address:
Street, City, State, Zip,
(County– for Iowa addresses only)

Work Phone:

Applicant E-mail:

Other E-mail:

Mailing Address: This address will be the address used for all correspondence from this office.

Work Home

Social Security Number:

Privacy Act Notice: Disclosure of your Social Security Number on this license application is required by 42 U.S.C. Section 666(a)(13) and Iowa Code Section 252J.8(1). The number will be used in connection with the collection of child support obligations and as an internal means to accurately identify licensees, and may be shared with taxing authorities as allowed by law including Iowa Code Section 421.18.

Height: ft in **Weight:** lbs **Hair Color:** **Eye Color:**

Identifying Marks: Check if not applicable

U.S. Citizen? Yes No

If No, Visa Type or Alien Registration Number:

Applicant Name:

Section 3—Birth Information

Complete every item. Provide your date of birth in month/day/year format.

Date of Birth:	**City of Birth:**
State of Birth:	**Country of Birth:**
Father's Full Name:	
Mother's Full Name:	

Section 4—Medical Education

List all medical schools you have attended, even those you did not graduate from. Provide an explanation below if 1) it took longer than five years or fewer than four years to complete your medical education, 2) had a break in your medical education, or 3) the end date of your education is different than the date of your degree.

Institution	City, State, Country	From (Mo/Yr)	To (Mo/Yr)

Degree Received: **Date of Degree (Mo/Yr):**

A copy of my diploma is submitted herewith. I further state that I am the identical person to whom this diploma was granted, that the same was procured in the regular course of study without fraud or misrepresentation and that the copy presented is a true copy.

Explanation:

If you are an international medical graduate, are you currently certified by the Educational Commission for Foreign Medical Graduates (ECFMG) or did you complete a Fifth Pathway Program?

ECFMG: Yes No **Fifth Pathway Program:** Yes No

Applicant Name:

Section 5—Post-Graduate Medical Training

List all post-graduate training programs you have attended in the United States or Canada, even those you did not complete. List internships, residencies, and fellowships separately. Applicants applying for a special or temporary license must also list post-graduate training programs attended outside the United States or Canada.

Name of Facility: **Address:** **(Street, City,** **County, State, Zip)**	**From (Mo/Yr)**	**To (Mo/Yr)**
Type of Training: Intern Resident Chief Resident Fellow Research		
Program Specialty:		

Name of Facility: **Address:** **(Street, City,** **County, State, Zip)**	**From (Mo/Yr)**	**To (Mo/Yr)**
Type of Training: Intern Resident Chief Resident Fellow Research		
Program Specialty:		

Name of Facility: **Address:** **(Street, City,** **County, State, Zip)**	**From (Mo/Yr)**	**To (Mo/Yr)**
Type of Training: Intern Resident Chief Resident Fellow Research		
Program Specialty:		

Name of Facility: **Address:** **(Street, City,** **County, State, Zip)**	**From (Mo/Yr)**	**To (Mo/Yr)**
Type of Training: Intern Resident Chief Resident Fellow Research		
Program Specialty:		

Applicant Name:

Section 6—Chronology of Activities

Provide a chronological listing of all medical and non-medical activities from the date you entered medical school to the present date, with no gaps in time. Do not substitute a resume or a curriculum vitae for this section. Include exact nature, location, and time frame of each activity. For any non-working time, you must state on the form exactly what your activities were such as "vacation" or "seeking employment." Applicants may copy this page or attach additional sheets of paper, labeled with your name and signed by you, if more space is needed.

Activity	Location (City/State)	From (Mo/Yr)	To (Mo/Yr)

Applicant Name:

Section 7—Hospital Privileges

List hospitals where you were granted privileges within the last five years. Do not list hospital privileges that were granted to you as part of your post-graduate training program. Do not guess on the dates of your privileges; verify the dates with the facility prior to completing the application. You will be required to correct any incorrect dates.

Not Applicable, check here if you have not held any hospital privileges that were not part of your training program.

Hospital Name	Address	From (Mo/Yr)	To (Mo/Yr)

Applicant Name:

Section 8— Medical/Osteopathic License Information

List all state and Canadian provinces where you currently hold or have held any type of medical/osteopathic license. Do not guess on the license number or original issue date of your license, verify the information with the licensing agency prior to completing the application. You will be requested to correct any incorrect information. Applicants applying for a special or temporary license must also list licenses held outside the United States or Canada.

Not Applicable, check here if you have never held any medical/osteopathic licenses.

State/Country	**License Number**	**Original Issue Date (Mo/Yr)**	**License Type** (i.e. Training, Permanent)

Section 9— Other Professional License Information

List all state and Canadian provinces where you currently hold or have ever held any professional license, such as a chiropractic, nursing, or physician assistant license. Applicants applying for a special or temporary license must also list licenses held outside the United States or Canada.

Not Applicable, check here if you have not held any other professional licenses.

State/Country	**License Number**	**Original Issue Date (Mo/Yr)**	**License Type & Profession** (i.e.Training/Nurse)

Applicant Name:

Section 10—Examination Information

Indicate the license examination you have taken. If you took a combination of examinations, indicate all that are applicable to your examination history. Applicants who took longer than seven years to pass the USMLE or COMLEX are required to be specialty board certified by a member board of the American Board of Medical Specialties or the American Osteopathic Association. Applicants who do not meet this rule will need to request a waiver of this licensure rule. Contact the Director of Licensure & Administration at (515) 281-6492 to discuss requesting a waiver of this rule.

USMLE	**Did you pass Steps 1-3 within ten years?**	**Yes**	**No**
COMLEX	**Did you pass Levels 1-3 within ten years**	**Yes**	**No**

NBME

NBOME

FLEX

LMCC

State Board Examination **State:**

SPEX Examination within the last ten years

Not Applicable

Section 11—Practice Information

List your proposed Iowa practice or proposed post-graduate training location. If it is unknown, please explain. Indicate if you are specialty board certified by an American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) specialty board. If you are applying for a temporary or special license, list the specialties for which you are certified and indicate in which country.

Proposed Iowa Practice or Proposed Post-Graduate Training Program Address:
(Institution/Group, Street, City, State, Zip Code)

Are you ABMS specialty board certified?	Yes	No
Are you AOA specialty board certified?	Yes	No
Are you specialty certified in another country?	Yes	No

Specialty:	**Date Certified:**	**Country:**
1.	1.	1.
2.	2.	2.
3.	3.	3.

Applicant Name:

Section 12— Question Definitions

It is important to review the definitions below before answering the questions in this section.

"Ability to practice medicine with reasonable skill and safely" means all of the following: The cognitive capacity to make appropriate clinical diagnoses, to exercise reasoned medical judgments and to learn and keep abreast of medical developments; The ability to communicate medical judgments and information to patients and other health care providers; and The capability to perform medical tasks such as physical examinations and surgical procedures, with or without the use of aids or devices.

"Medical condition" means any physiological, mental or psychological condition, impairment or disorder, including drug addiction and alcoholism.

"Chemical substances" means alcohol, legal and illegal drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" The medical condition has had an ongoing or adverse impact on the ability to function and practice.

"Improper use of drugs or other chemical substances" means all of the following: The use of any controlled drug, legend drug or other chemical substance for any purpose other than as directed by a licensed health care practitioner; and the use of any substance, including, but not limited to, petroleum products, adhesive products, nitrous oxide and other chemical substances for mood enhancement.

"Illegal use of drugs or other chemical substances" means the manufacture, possession, distribution or use of any chemical substances prohibited by law (e.g. heroin).

Iowa Physician Health Program (IPHP)

The IPHP is a confidential, voluntary program offered to physicians who may be dealing with impairment issues, such as, but not limited to alcohol or drug abuse, dependency or addiction, neuropsychiatric disorder, or physical disability. The IPHP develops an individualized program for each physician, with the goal of allowing the physician to continue to practice with reasonable skill and safety. Oftentimes, the Licensure Committee of the Board will refer physicians with impairment issues to the IPHP for review and bases licensure decisions on its recommendations.

To self-report to the IPHP or obtain additional information, contact the Coordinator of IPHP at 515-281-6491.

Applicant Name:

Section 12—Questions

Respond "yes" or "no" to each item. The Board expects full disclosure of events, whether you consider them to be minor or major in nature. It is better to disclose information than to not disclose it.

For every "yes" response, you must provide a separate statement of explanation that is signed and dated. This statement must include full details, including dates, locations, actions, organizations or parties involved. You must also provide the requested supporting documentation. The Board may request additional supporting information, if needed.

A criminal background check packet will be sent to your home address after your application has been submitted. Your answer to question #6 of the application and the question on the background check waiver should contain the same information. Discrepancies between the application and the criminal background check waiver could result in disciplinary action. Some states have court records available online, which you may want to review if you are unsure how to answer this question. Iowa's court record website is www.iowacourts.state.ia.us.

Applicants must answer all questions. Current IPHP participants, may answer "No" to questions 1 through 5.

Yes No

1. Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?
   If yes, provide a description of your condition and submit the "Verification of Medical Condition" form which is to be completed by your treating physician(s).

2. Are you receiving ongoing treatment or participating in a monitoring program that reduces or eliminates the limitations or impairments caused by either your medical condition or use of alcohol, drugs, or other chemical substances?
   If yes, provide details of your treatment or program, copies of treatment evaluations, statement from the program indicating your progress and practice recommendations.

3. Does your field of practice, or the setting or the manner in which you have chosen to practice medicine, reduce or eliminate the limitations or impairments caused by your medical condition or use of alcohol, drugs or other chemical substances?
   If yes, provide a description of your practice and how it has changed since the diagnosis of your medical condition.

4. Are you currently engaged in the illegal or improper use of drugs or other chemical substance?
   If yes, provide an explanation.

5. Does your current use of alcohol, drugs or other chemical substances in any way impair or limit your ability to practice medicine with reasonable skill and safety?
   If yes, explain your current usage and how this impairs your ability to practice.

Applicant Name:

Yes No

6. Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to a crime other than a minor traffic offense, in any jurisdiction? You must include all misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record of conviction. (For example, you must report if your conviction was expunged, you received a deferred judgment, or you received an executive pardon.) Driving under the influence or driving while impaired is not a minor traffic offense.

If yes, provide details of the charge and the final outcome. Provide copies of any court/legal documents related to each incident.

7. During medical school, were you ever terminated, requested to withdraw, asked to repeat training or education or placed on probation?

If yes, provide an explanation.

8. Have you ever received a certificate of non-compliance from the College Student Aid Commission regarding non-payment of a student loan?

If yes, provide an explanation.

9. Have you ever been terminated, asked to withdraw, or asked to repeat a portion of an internship, residency, or fellowship?

If yes, provide an explanation.

10. Have you ever received a warning or reprimand, been asked to participate in remediation or been placed on probation during an internship, residency or fellowship program?

If yes, provide an explanation.

11. Have you ever taken a leave of absence for any reason (maternity, family, personal, financial, military service, research, study for licensure exam or board certification, etc.) during your medical school education, internship, residency, or fellowship?

If yes, provide an explanation.

12. Have you ever been denied a license to practice medicine or a license to practice another profession?

If yes, provide an explanation and a copy of the notice of denial.

13. Have you ever surrendered any professional license for any reason?

If yes, provide an explanation and a copy of all official documents relating to the surrender.

13a. If yes, was a license disciplinary action pending against you or were you under investigation by a professional licensing agency at the time you surrendered the license?

If yes, provide an explanation and a copy of all related official documents.

14. Have you ever been denied a Drug Enforcement Administration (DEA) or state controlled substance registration certificate?

If yes, provide an explanation and a copy of the notice of denial.

Applicant Name:

Yes No

15. Have you ever surrendered your state or controlled substances registration or had it restricted in any way?

If yes, provide an explanation and a copy of all official documents relating to this.

16. Aside from ordinary initial requirements of proctorship, have you ever had your clinical privileges or medical staff status at any hospital or health care entity, nursing facility, clinic, or other professional health care organization limited, suspended, revoked, not renewed, voluntarily or involuntarily modified, relinquished, denied, or subject to other disciplinary or probationary conditions while under investigation, peer review or disciplinary action? *You may answer 'No' if you voluntarily relinquished or did not renew your privileges due to a change in job, retirement, etc. as long as you were not under investigation or review at that time.*

If yes, provide an explanation and a copy of all related official documents.

17. Have you ever been terminated, sanctioned, penalized, had to repay monies to or been denied provider participation in any Medicaid, Medicare or other publicly funded healthcare program?

If yes, provide an explanation and a copy of all related official documents.

18. Have you ever been denied membership or renewal or been subject to any disciplinary action, sanction or warning in any medical or osteopathic organization or professional society?

If yes, provide an explanation and a copy of all related official documents.

19. Have you ever been investigated or subject to an inquiry/review by any professional licensing agency, including investigations or reviews which resulted in no formal action? (Answer "Yes" if you have ever been contacted by an investigator or Board agent to review a complaint or report filed against you.)

If yes, provide an explanation of the inquiry, including dates, state, charges, final outcome and a copy of all related official documents

20. Has any jurisdiction of the U.S. or other nation ever limited, restricted, warned, censured, placed on probation, suspended, revoked or filed charges against any license you held?

If yes, provide an explanation and a copy of all related official documents.

21. Are you in violation of any child support order or written agreement to pay child support?

If yes, provide an explanation.

22. Have any professional liability suits ever been filed against you?

If yes, complete the attached Professional Liability Suit Information form along with a copy of the requested legal documents listed on that form.

23. Have any judgments or settlements been paid on your behalf as a result of a professional liability case?

If yes, complete the attached Professional Liability Suit Information form along with a copy of the requested legal documents listed on that form.

Applicant Name:

Section 13— Affidavit of Applicant

Enter the state and county in which the affidavit is being notarized. Sign the affidavit in the presence of a notary. The notary must supply the jurisdiction at the beginning of the affidavit, sign, enter the date of the notarization, and the expiration date of his/her commission. Attach a recent photo of yourself that has been taken within the last 90 days.

State of: _____ **County of:** _____

I,_____

hereby swear or affirm, under penalty of perjury, that I am the person described and identified; that the attached photo is a true likeness of myself; that I am the person named in the diploma which accompanies this application; that I am the lawful holder of said diploma; that said diploma was procured in the regular course of instruction and examination without fraud or misrepresentation.

I certify that I have carefully read the questions on this application and have answered them completely and truthfully. I declare under penalty of perjury that my answers, and all other statements or information submitted by me in this application process, are true and correct. If it is determined at any time that I have provided misleading or false information on or in support of this application, I understand that my application may be denied or that I may be subject to disciplinary action and criminal prosecution if I am already licensed.

I understand that I am required to update answers or information submitted with this application if the response or the information changes during the time period the application is pending. I also understand that this application is a public record in accordance with Iowa Code chapter 22 and that application information is public information, subject to the exceptions contained in Iowa law. Finally, in submitting this application, I consent to any reasonable inquiry that may be necessary to verify the information I have provided on or in conjunction with this application.

I also declare, under penalty of perjury, that if I did not personally complete the foregoing application that I have fully read and confirmed each question and accompanying answer and take full responsibility for all answers contained in this application.

_____

Signature of Applicant

_____

Signature of Notary Public

_____

Sworn/Affirmed to before me on

_____

My commission expires:

_____

Notary Seal or Stamp:

ATTACH A RECENT PHOTO THAT HAS BEEN TAKEN WITHIN THE LAST 90 DAYS HERE

Office Use Only
License Number: _____
Issue Date: _____
Expiration Date: _____
Initials: _____

Applicant Name:

Section 14— Authorization for Release of Information
All applicants must sign and date this section.

I, _____ (print name), do hereby authorize a disclosure of records concerning myself to the Iowa Board of Medicine (IBM). This release includes records of a public, private or confidential nature.

I acknowledge that the information released to the IBM may include material that is protected by federal and/or state laws applicable to substance abuse and mental health information. If applicable, I specifically authorize the release of confidential information to and from the IBM relating to substance abuse or dependence and/or mental health.

I further agree that the IBM may receive confidential information and records, including, but no limited to the following records:

- Medical Records
- Education Records
- Personnel or employment records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Post-graduate training (internship, residency, & fellowship) records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Any information the IBM deems reasonably necessary for the purposes set forth in this Release.

Release of Liability. I do hereby irrevocably and unconditionally release, covenant not to sue, and forever discharge any person or entity, including but not limited to any medical school, residency or fellowship training program, hospital, health care provider, health care facility, licensing board, impaired practitioner program, agency or organization which releases information to the IBM pursuant to this release from any liability, claim, or cause of action arising out of the release of such information. I further irrevocably and unconditionally release, covenant not to sue, and forever discharge the IBM, the state of Iowa and its employees and agens from many liability, claim, or cause of action arising out of the collection or release of information pursuant to this release.

A photocopy of this release form will be valid as an original thereof, even though the photocopy does not contain an original writing of my signature.

This authorization is valid until completion of the licensure process. I understand I have the right to revoke this authorization in writing, except to the extent that the IBM has already taken action in reliance upon this consent.

I have read and fully understand the contents of this “Authorization to Release Information.”

_____ _____

Signature of Applicant Date

PROHIBITION ON REDISCLOSURE

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R.Part 2) and state requirements (Iowa Code Ch 228) prohibit further disclosure without the specific written consent of the patient except as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.

Applicant Name:

Checklist for Temporary Iowa Physician Licensure

Use this checklist to ensure that you are submitting the appropriate documents for temporary licensure.

Do not send this form back to the Iowa Board of Medicine.

_____ Completed application & application fee of $145 sent to the Board

_____ Affidavit and Authorization for Release of Information form sent to the Board

_____ Copy of any medical license you hold to the Board

_____ Verification of Licensure form sent to the Board from all countries in which you have ever held medical and/or other professional license outside the U.S. or Canada

_____ Request a letter from the organization/individual seeking your service that explains the need for your participation in the board-approved activity, the time period involved, scope of practice, the exact location/facilities of the activity, and who the immediate supervisor will be.

_____ Fluency in English language demonstrated by having either a valid ECFMG certificate or a passing score on the TSE or TOEFL, if you are an international medical graduate who does not have a U.S. or Canadian medical license.

_____ Statement Justifying Need for License sent to the Board

_____ Supporting documentation of any legal name change sent to the Board

_____ Copy of medical diploma sent to the Board

Iowa Board of Medicine
400 SW 8th Street, Suite C, Des Moines, IA 50309-4686
(515) 281-6641 www.medicalboard.iowa.gov

Professional Licensure Verification

Applicant: Submit this form to each jurisdiction where you were issued a license. Complete the top portion and page two of the form only and submit the form to the appropriate licensing agency.

State or Provincial Licensure Board: Complete and mail the form directly to the Iowa Board of Medicine. Any processing fees are the applicant's responsibility.

Applicant's Name (Print Legibly): _____

Applicant's Date of Birth (Month/Day/Year): _____

It is hereby certified that _____
(Name of Licensee)

Date of Birth: _____ Profession: _____ Issued License Number: _____

By _____ On _____
(State or Province) (Month/Year)

License Type: Permanent _____ Training/Educational _____ Temporary _____ Other _____

Has the licensee ever been investigated or had a complaint filed against him/her?
Yes _____ No _____ Unable to Disclose _____
If Yes, provide a copy of the documentation related to the investigation or complaint.

Has disciplinary action ever been initiated, invoked, or is disciplinary action pending?
Yes _____ No _____ Unable to Disclose _____
If Yes, provide a copy of the documentation related to the disciplinary action.

Has the licensee ever voluntarily relinquished their medical license?
Yes _____ No _____ Unable to Disclose _____
If Yes, provide a copy of the documentation related to this event.

Institutional Seal

If the institution does not have an official seal, the form must be notarized.

Completed by State or Provincial Licensure Board:

Print Name: _____

Signature: _____

Date (month/day/year): _____ Phone: _____

Fax: _____ E-mail: _____

Authorization for Release of Information-Verification of Licensure

The applicant must sign this form and submit it with the Verification of Licensure form. The licensing agency may retain this release of information for their own records.

I, _____ (print name), do hereby authorize a disclosure of records concerning myself to the Iowa Board of Medicine (IBM). This release includes records of a public, private or confidential nature.

I acknowledge that the information released to the IBM may include material that is protected by federal and/or state laws applicable to substance abuse and mental health information. If applicable, I specifically authorize the release of confidential information to and from the IBM relating to substance abuse or dependence and/or mental health.

I further agree that the IBM may receive confidential information and records, including, but no limited to the following records:

- Medical Records
- Education Records
- Personnel or employment records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Post-graduate training (internship, residency, & fellowship) records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Any information the IBM deems reasonably necessary for the purposes set forth in this Release.

Release of Liability. I do hereby irrevocably and unconditionally release, covenant not to sue, and forever discharge any person or entity, including but not limited to any medical school, residency or fellowship training program, hospital, health care provider, health care facility, licensing board, impaired practitioner program, agency or organization which releases information to the IBM pursuant to this release from any liability, claim, or cause of action arising out of the release of such information. I further irrevocably and unconditionally release, covenant not to sue, and forever discharge the IBM, the state of Iowa and its employees and agens from many liability, claim, or cause of action arising out of the collection or release of information pursuant to this release.

A photocopy of this release form will be valid as an original thereof, even though the photocopy does not contain an original writing of my signature.

This authorization is valid until completion of the licensure process. I understand I have the right to revoke this authorization in writing, except to the extent that the IBM has already taken action in reliance upon this consent.

I have read and fully understand the contents of this “Authorization to Release Information.”

_____ _____

Signature of Applicant Date

PROHIBITION ON REDISCLOSURE

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R.Part 2) and state requirements (Iowa Code Ch 228) prohibit further disclosure without the specific written consent of the patient except as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.

Iowa Board of Medicine
400 SW 8th Street, Suite C, Des Moines, IA 50309-4686
(515) 281-6641 www.medicalboard.iowa.gov

Professional Liability Suit Information

Applicant: Complete this form each suit you have been named a party. Summaries of this information from insurance carriers is not acceptable. Submit the requested documentation for each suit. You do not need to submit this form if you have not been named in a professional liability suit.

Name of patient/plaintiff:

Date of event:

Date of suit:

Does the suit involve any of the following?

Yes No

- Death of the patient
- Wrong sided surgery
- Loss of limb or major organ

What is/was your role in the suit or claim:

- Primary defendant
- Co-defendant
- Other

Status of Suit & Documents to Submit:

Pending—Submit copy of complaint and a letter from your attorney indicating the status of the case.

Dismissed—Submit copy of the dismissal order.

Settled— Submit copy of complaint, final disposition, and settlement/release.
Amount Settled on Your Behalf_____

Other

Describe the allegations:

Describe your involvement in the care of the patient:

Applicant Name (Print Name): _____

Applicant Signature: _____ **Date:** _____

Iowa Board of Medicine
400 SW 8th Street, Suite C, Des Moines, IA 50309-4686
(515) 281-6641 www.medicalboard.iowa.gov

Verification of Medical Condition

Applicant: You are required to provide a statement explaining any medical condition you have experienced that has had an ongoing or adverse impact on your ability to function and practice. Physicians who had a condition that interrupted their education or training should also complete this form.

The physician who diagnosed and provides, or provided, treatment for the condition should complete the form.

Treating Physician: Complete and mail the form directly to the Iowa Board of Medicine. This form is also on our website as a pdf document which can be completed using the computer and printing the document. The applicant's signature on page three of this form authorizes the release of information, favorable or otherwise, directly to the Board.

Applicant's Name (Print Legibly):_____

Applicant's Date of Birth (Month/Day/Year):_____

Nature of Medical Condition (include specific diagnosis):

Summary of Treatment:

Treatment Period: From To

Recommended Treatment:

Is/Was the applicant in compliance with his/her treatment? Yes No
If no, please explain.

Is the applicant taking any prescribed medications for this condition? Yes No
If yes, please list the medication(s).

Provide a summary of other prescription medications this applicant is taking.

Has this medical condition in any way affected the applicant's ability to practice medicine with reasonable skill and safety? Yes No
If yes, please explain.

Do any limitations need to be in place with regard to the applicant's practice of medicine?
Yes No
If yes, please explain.

If treatment were to cease for any reason, could the applicant's condition in any way affect his/her ability to practice medicine with reasonable skill and safety? Yes No
If yes, please explain.

Is ongoing monitoring warranted? Yes No
If yes, please explain.

Treating Physician Information:

Name (print legibly): _____

Signature: _____ **Date:** _____

Address: _____

Phone: _____ **Fax:** _____

Authorization for Release of Information-Verification of Medical Condition

The applicant must sign this form and submit it with the Verification of Medical Condition form. The treating physician may retain this release of information for his/her own records.

I, _____ (print name), do hereby authorize a disclosure of records concerning myself to the Iowa Board of Medicine (IBM). This release includes records of a public, private or confidential nature.

I acknowledge that the information released to the IBM may include material that is protected by federal and/or state laws applicable to substance abuse and mental health information. If applicable, I specifically authorize the release of confidential information to and from the IBM relating to substance abuse or dependence and/or mental health.

I further agree that the IBM may receive confidential information and records, including, but no limited to the following records:

- Medical Records
- Education Records
- Personnel or employment records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Post-graduate training (internship, residency, & fellowship) records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Any information the IBM deems reasonably necessary for the purposes set forth in this Release.

Release of Liability. I do hereby irrevocably and unconditionally release, covenant not to sue, and forever discharge any person or entity, including but not limited to any medical school, residency or fellowship training program, hospital, health care provider, health care facility, licensing board, impaired practitioner program, agency or organization which releases information to the IBM pursuant to this release from any liability, claim, or cause of action arising out of the release of such information. I further irrevocably and unconditionally release, covenant not to sue, and forever discharge the IBM, the state of Iowa and its employees and agens from many liability, claim, or cause of action arising out of the collection or release of information pursuant to this release.

A photocopy of this release form will be valid as an original thereof, even though the photocopy does not contain an original writing of my signature.

This authorization is valid until completion of the licensure process. I understand I have the right to revoke this authorization in writing, except to the extent that the IBM has already taken action in reliance upon this consent.

I have read and fully understand the contents of this “Authorization to Release Information.”

_____ _____

Signature of Applicant Date

PROHIBITION ON REDISCLOSURE

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R.Part 2) and state requirements (Iowa Code Ch 228) prohibit further disclosure without the specific written consent of the patient except as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.

Iowa Board of Medicine
400 SW 8th Street, Suite C, Des Moines, IA 50309-4686
(515) 281-6641 www.medicalboard.iowa.gov

Temporary License Letter Guide

Applicant Instructions: Provide this guide to the Iowa licensed physician that is requesting your services.

Iowa Licensed Physician Instructions: A requirement for temporary licensure is a letter from the physician requesting the applicant's services. Use this guide to write the letter and include information for each of the items below. Letters that fail to address the items below will be requested to resubmit their letter with additional information. This letter can be mailed directly to the board.

Observing in Iowa: Iowa rules allow physicians to observe without obtaining a license. Physicians who are going to observe do not qualify for a temporary license. Do not submit an application if the activity is solely observation. The board will not approve licenses for observation.

1. Applicant name.
2. Name of Iowa licensed physician that requests the applicant's services and their contact information.
3. Name the applicant's immediate supervisor and their contact information.
4. Length of time the applicant will be participating in the board approved activity.
5. Location(s) of the activity.
6. Description of the need to have the applicant licensed.
7. Explain in detail the following information.
    - Type of practice in which the applicant will be involved.
    - Indicate if patient contact will occur.
    - List the procedures the applicant will learn.
    - List the procedures the applicant will perform.
    - List any research projects in which the applicant will be involved.
    - Indicate if the applicant will act as a consultant to the Iowa licensed physician.
    - Provide any other details of the applicant's proposed practice in Iowa that is not covered by the above items.
8. Sign and date letter.